## ANNUAL CHILD MALTREATMENT FATALITY REPORT

July 1, 2003 – June 30, 2004

#### TABLE OF CONTENTS

Executive Summary	1
Recommendations	2
Fatalities by Locality	3
Children Who Died from Maltreatment	4
Caretakers Responsible for Child Deaths	6
Types of Abuse and Neglect	8
Families Known to the Child Welfare System	10
Actions in Fiscal Year 2004	11
Appendix: Table of Cases	12

Prepared by: Child Protective Services Program Virginia Department of Social Services Revised March 3, 2005

#### **EXECUTIVE SUMMARY**

- Local departments of social services investigated 64 reports of child deaths suspected to be caused by child maltreatment for fiscal year July 1, 2003, to June 30, 2004. Reports were founded for 29 children, the same number of founded fatalities as in fiscal year 2003. However, dispositions are still pending or under appeal for three deaths.
- Fifteen of the children died as a result of abuse, and 14 died as a result of neglect.
- Children reported in fiscal year 2004 ranged in age from three months to 17 years. Of the 29 children who died from maltreatment, 21 were three years of age or younger. This is consistent with national data that have found young children to be the most vulnerable.
- One or both parents were responsible for the deaths of 19 (66 percent) of the children. National data have found parent(s) to be responsible for about 80 percent of child maltreatment deaths.
- Of the caretakers found responsible for the deaths, 22 were women and 10 were men. This is a greater proportion of females than in past years. Nationally there are more female than male perpetrators. The median age of all responsible females was 25 years. The median age of all responsible males was 30 years. National data that have found most caretakers to be young adults in their mid-twenties.
- Families of half of the children who died were known to the child welfare system in some capacity. These families were more likely to have experienced problems with mental health, domestic violence, and substance abuse.
- The Virginia Department of Social Services continues to support a number of collaborative efforts at the state and local levels to decrease the number of child fatalities in Virginia.

#### RECOMMENDATIONS

#### Goal: Promote interagency partnerships to prevent child fatalities

- Complete development of a statewide plan for the prevention of child abuse and neglect. Disseminate and market the plan to professionals and the general public.
- Continue to serve on the State Child Fatality Review Team. This team will release findings from its review of caretaker homicides and will make recommendations for prevention. The team has initiated a review of hyperthermia deaths of children left unattended in automobiles.
- Continue to provide leadership to the Hampton Roads Regional Child Fatality Review Team.
- Continue to provide leadership to the Piedmont Regional Child Fatality Review Team.
- Continue to collaborate with the Office of the Chief Medical Examiner on the National Violent Death Reporting System.
- Continue collaboration through the Safe Families Recovery Project to develop an interagency strategic plan to address the needs of families in the child welfare and court systems affected by substance abuse and addiction.

#### Goal: Reduce child maltreatment fatalities among infants and young children.

- Pilot structured decision making tools to guide child protective services and foster care workers in the safety and protection of children.
- Broaden agency practice in Hampton Roads to share information with the Family Advocacy Program of the United States Army in CPS family assessment cases.
- Train child protective services workers in Hampton Roads on how to recognize and assess postpartum depression.
- Continue to fund community-based Healthy Families programs serving families with infants and young children.
- Continue to target other child abuse prevention funds to services for families with infants and young children.
- Create an Office of Family Violence within the Department of Social Services to strengthen community-based domestic violence services and promote training of child protective services workers and others.
- Examine the cases the child deaths where the family had been previously known to the child welfare system to determine what similarities and commonalities existed.

#### **FATALITIES BY LOCALITY**

### Deaths of Children Investigated By CPS in FY 2004

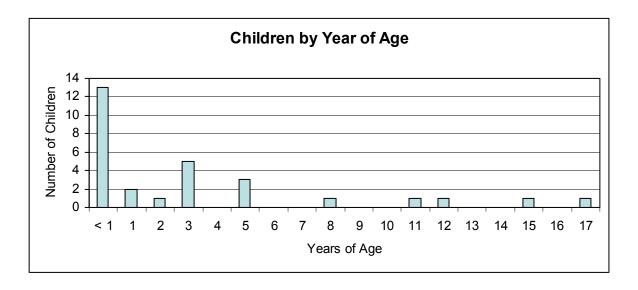
Locality	Founded	Unfounded	Pending/ Appealed	Total Deaths Investigated
Appomattox		1		1
Botetourt	1			1
Bristol	1			1
Buckingham	1			1
Campbell		1		1
Chesapeake	2*	2		4*
Chesterfield	2			2
Dickenson		1		1
Fairfax	2			2
Fauquier		1		1
Halifax		1		1
Hampton		1		1
Henrico	2*	1		3*
Henry	1	1		2
Lunenburg		1		1
Lynchburg	1			1
Manassas City		1		1
Mecklenburg			1	1
Newport News	3*	1		4*
Norfolk	3	2		5
Northumberland	1			1
Petersburg	1			1
Portsmouth	1	1		2
Prince Edward			1	1
Richmond City	1	8	1	10
Roanoke City	2			2
Rockingham		1		1
Southampton	1			1
Spotsylvania		1		1
Stafford		1		1
Staunton		1		1
Suffolk		1		1
Sussex	1			1
Washington	1			1
Virginia Beach	1	3		4
Totals:	29	32	3	64

<sup>\*</sup>Three incidents each resulted in two deaths.

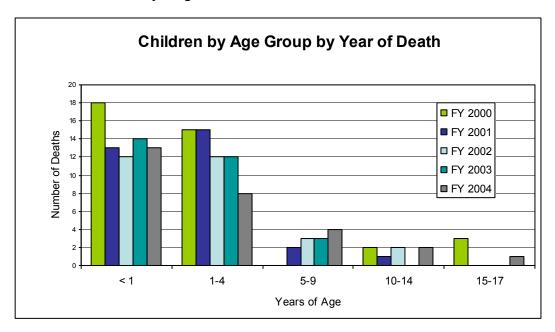
During fiscal year 2004, local departments of social services received reports of 66 child fatalities where child abuse or neglect was suspected. One report was determined to be invalid, and one investigation could not be completed. Reports were founded for 29 children and unfounded for 32 children. Dispositions are pending or appealed for 3 children.

One-third (10) of the founded deaths occurred in the Hampton Roads area of the state. This is a rate of 2.4 deaths per 100,000 children compared to 1.6 for the state as a whole.

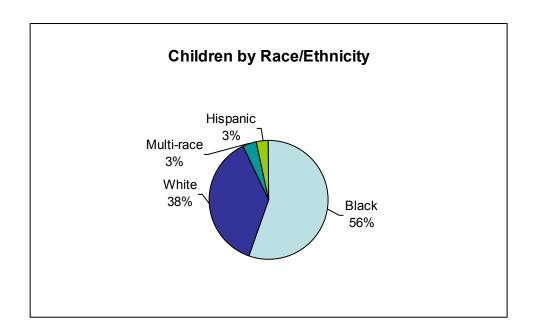
#### CHILDREN WHO DIED FROM MALTREATMENT



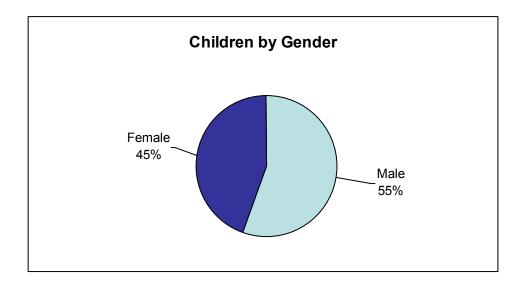
Children who died from maltreatment in fiscal year 2004 ranged in age from 3 months to 17 years. While there were more older children than in recent past years, young children continued to be at highest risk of death from maltreatment. Of the 29 children who died from maltreatment, 21 (72 percent) were three years of age or younger. Thirteen (45 percent) were less than 1 year of age. This is consistent with national data that have found young children to be the most vulnerable.



The number of child maltreatment deaths declined from 38 deaths that occurred in FY 2000 to 29 deaths that occurred in FY 2004. The decline is among children less than 5 years of age.

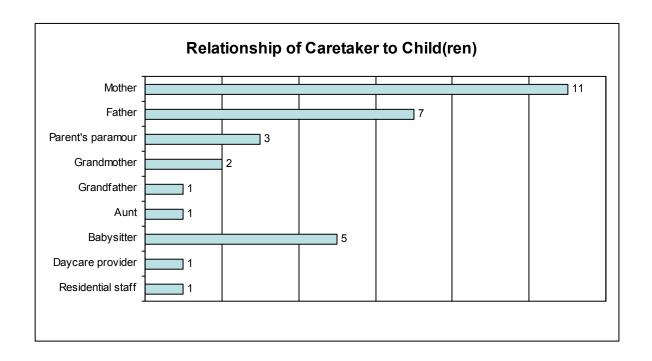


Over half (16) of the children who died of maltreatment were black or African American. Eleven were non-Hispanic white, 1 was Hispanic white, and 1 was bi-racial. This is consistent with national data that have found black or African American children to be over-represented.



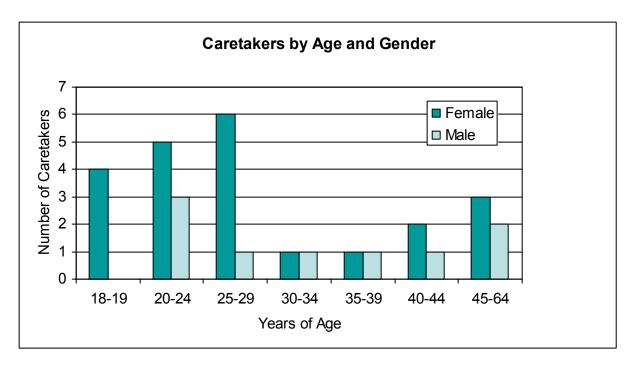
There were more deaths among boys (16) than girls (13). This is consistent with national data which have found boys to have a higher rate of maltreatment fatalities than girls.

#### CARETAKERS RESPONSIBLE FOR CHILD DEATHS



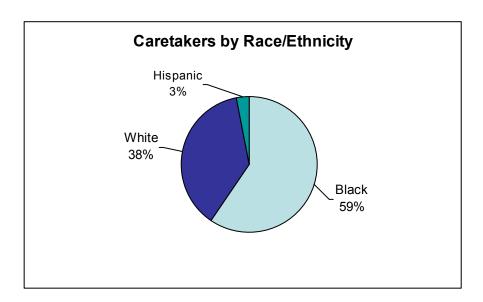
Local departments of social services found 32 caretakers to be responsible for the deaths of 29 children reported in fiscal year 2004. One or both biological parents were found to be responsible for 19 (66 percent) of the deaths. National data that have found parent(s) to be responsible for about 80 percent of child maltreatment deaths.

The biological mother was found responsible for the deaths of 13 children, including two sibling pairs neglected by their mothers. The biological father was found responsible for the deaths of 8 children, including one sibling pair neglected by their father. The mother's paramour was responsible for 2 deaths, father's paramour for 1 death, grandmother for 2 deaths, grandfather for 1 death, and aunt for 1 death. Babysitters were found responsible for five deaths, a licensed family daycare provider for one death, and residential facility staff for one death.



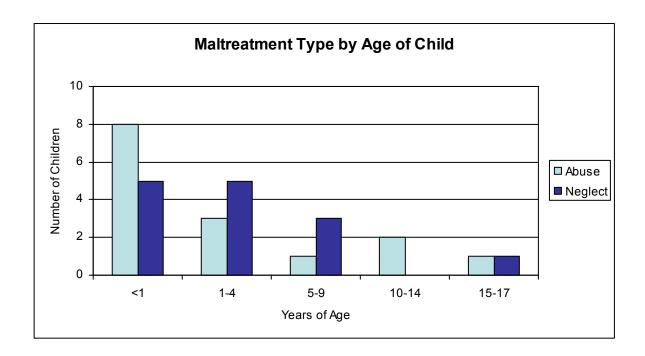
Of those caretakers found to be responsible for child deaths, 22 were female and 10 were male. This is a greater proportion of females than in past years. Nationally there are more female than male perpetrators.

The median age of all responsible females was 25 years. The median age of all responsible males was 30 years. Age is unknown for one male caretaker. National data that have found most caretakers to be young adults in their mid-twenties.



Nineteen caretakers were black or African American, 12 were non-Hispanic white, and 1 was Hispanic white.

# TYPES OF ABUSE AND NEGLECT



Fifteen (52 percent) of the children died as a result of abuse and 14 (48 percent) died as a result of neglect. Children less than a year of age were more likely to die from abuse than from neglect.

#### **Cause of Death by Maltreatment Type**

Cause of Death	Abuse	Neglect	Total
Shaking	6		6
Trauma	3	2	5
Gunshot	2	2	4
Fire	1	3	4
Drowning		3	3
Asphyxia	2		2
Scalding	1		1
Malnutrition		1	1
Other		3	3
Total	15	14	29

Six children died from brain injury as a result of shaking. Five children died of other trauma. Two children were shot by a parent who then committed suicide, and two children accidentally shot themselves with a firearm in the home. Four children died in house fires. Three children drowned as the result of inadequate supervision. Two children were asphyxiated, one child was scalded, and one child died of malnutrition and inadequate care. Three neglected children died of undetermined causes.

#### Child Deaths with Identified Risk Factors

Risk Factor	Child	Family	Babysitter
Previous CPS involvement		14	1
Mental health/ behavioral	2	3	
Domestic violence		4	
Substance abuse		3	
Mental retardation		1	

Identified risk factors in the families of the children who died subsequent to abuse and neglect include previous child protective services involvement, mental health/ behavioral problems, domestic violence, substance abuse, and mental retardation.

#### FAMILIES KNOWN TO THE CHILD WELFARE SYSTEM

Although no child was the subject of a previous founded report of child abuse or neglect, half of the children's families or caretakers had been known to the child welfare system in some capacity. This increase over past years in families known to the child welfare system may reflect the increased ability to identify families with multiple reports through the Online Automated Services Information System (OASIS) rather than an actual increase.

- One babysitter had an open child protective services on-going case due to past abuse of her own child.
- The responsible parents of three children were found to have abused or neglected other children.
- The neglectful mother of two deceased children was a former foster child, and the abusive parent of another child had been a victim of child abuse herself.
- An assessment of one child's family four months prior to the death had found no need for services.
- A report of suspected neglect of one child was screened out the month before the fatal abuse.
- Families of six other children had received one or more investigations or family assessments in the past.
- There is no record of previous child protective services involvement with the child, family, or abusive/neglectful caretaker in the remaining 13 (48 percent) of the deaths.

Compared to families and caretakers with no previous child welfare involvement, families and caretakers previously known to the child welfare system were more likely to have experienced mental health or behavioral problems (parent of 3 children), domestic violence (parents of 3 children), and substance abuse (parent of 2 children). Research substantiates that these factors are associated with child abuse and neglect. These factors are considered in the structured decision making tool for assessing risk of future abuse and neglect that is being piloted for use by all child welfare workers in the state.

#### **ACTIONS IN FISCAL YEAR 2004**

# Actions taken to assess the problem of child maltreatment fatalities in Virginia and develop recommendations for prevention:

- The Commissioner of Social Services convened the Hampton Roads Child Fatality Summit to develop strategies for the prevention of child abuse and neglect fatalities.
- The Department of Social Services initiated development of a statewide plan for the prevention of child abuse and neglect.
- The State Child Fatality Review Team initiated a review of motor vehicle deaths, including hyperthermia deaths of children left unattended in an automobile.
- The Department of Social Services assisted the Office of the Chief Medical Examiner with data collection for the National Violent Death Reporting System.

#### Actions taken to prevent child maltreatment fatalities in Virginia:

The Department of Social Services:

- Collaborated with other statewide public and private organizations to sponsor regional forums on family violence.
- Collaborated with Prevent Child Abuse Virginia in developing and distributing educational materials for the Child Abuse Prevention Month campaign. The packet included a handout for parents on Safe Sleeping for Babies.
- Continued to conduct its Prevent Shaken Baby Syndrome public awareness campaign by distributing 18,430 copies, in English and Spanish, of a brochure entitled, "Never, ever, ever shake your baby!" The brochures were distributed to hospital maternity units and included in "Welcome Baby" information packets.
- Funded 36 local Healthy Families programs serving families with young children in 84 localities.
- Funded 26 other community-based prevention programs with emphasis on services to families with young children.